

MAY 15 1940
Registration District No.

791

Primary Registration District No.

1003

Registrar's No.

3466

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
PEOPLES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ONE DAY
(Specify whether
In this community 15 YEARS
years, months or days)

3. (a) PRINT FULL NAME ANTHONY FELTS 1132
8. (b) If veteran, name war NO 8. (c) Social Security No. NONE

4. Sex MALE 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive NONE years
7. Birth date of deceased UNKNOWN
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
35 - - 1 hr. 1 min.

9. Birthplace MISSISSIPPI
(City, town, or county) (State or foreign country)

10. Usual occupation LABOR

11. Industry or business BIERMAN IRON YARD

12. Name UNKNOWN

13. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Babe Castley

(b) Address 1209 Hadley St.

17. (a) GRIAL (b) Date thereof 4-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GREENWOOD CEMETERY

18. (a) Signature of funeral director C. W. Roberts

(b) Address 3035 Limes Ave.

19. (a) APR 16 1940 (b) J. H. Roberts
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS 25
(If outside city or town limits, write "RURAL")
(d) Street No. 1309 HADLEY ST.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 15 year 1940 hour _____ minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to Subdural Hemorrhage

Due to Diffuse Cerebral Sclerosis

Due to Chronic Parenchymatous

Other conditions (Include pregnancy within 3 months of death)

Major findings: Nephritis

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Joseph M. Quinn (M. D. or other) _____

Address Deputy Coroner Date signed _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Arthur L. Hilliard

Licensed Embalmer No. 3389

P. O. Address 3028 Dickson St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.